A Teaching Framework for Cross-cultural Health Care

Application in Family Practice

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Significant demographic changes in patient populations have contributed to an increasing awareness of the impact of cultural diversity on the provision of health care. For this reason methods are being developed to improve the cultural sensitivity of persons responsible for giving health care to patients whose health beliefs may be at variance with biomedical models.

Building on methods of elicitation suggested in the literature, we have developed a set of guidelines within a framework called the LEARN model. Health care providers who have been exposed to this educational framework and have incorporated this model into the normal structure of the therapeutic encounter have been able to improve communication, heighten awareness of cultural issues in medical care and obtain better patient acceptance of treatment plans.

The emphasis of this teaching model is not on the dissemination of particular cultural information, though this too is helpful. The primary focus is rather on a suggested process for improved communication, which we see as the fundamental need in cross-cultural patient-physician interactions.

Health care providers are finding themselves dealing with increasingly diverse patient populations. Fueled by armed conflict, political unrest and economic instability, the influx of immigrants into the United States is prompting a structural shift in the demographic representation of minorities. The impact is especially acute in states like California, which are subject to secondary migration or relocation after preliminary resettlement. These migration patterns, in combination with reproductive patterns, set a trend that is predictive of what has been termed *minoritization.*

In addition to language and socioeconomic barriers recognized to stand between minority populations and the health care system,[1-3] there is an increasing awareness of the impact of diverse health and disease belief systems on the interaction of health care providers and patients of a different cultural heritage.[4-10]

Overcoming these obstacles is aided by the incorporation of new tools for cross-cultural communication.* At the Family Practice Residency at San Jose Health Center, we have begun to develop a set of guidelines for health care providers in a practice that serves a multicultural patient population. We have structured these guidelines around the following mnemonic:

Guidelines for Health Practitioners: LEARN

- **L** *Listen* with sympathy and understanding to the patient's perception of the problem
- **E** *Explain* your perceptions of the problem
- **A** *Acknowledge* and discuss the differences and similarities
- **R** *Recommend* treatment
- **N** *Negotiate* agreement

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It should be emphasized that the LEARN model is not intended to replace completely the normal structure of the medical interview. Rather, it is intended as a supplement to history taking. The difference in focus is between a patient's factual subjective report of onset and duration and characteristics of symptoms and a patient's theoretical explanation of the reasons for the problem.

Discussion of Guidelines

Listen. Interview techniques have been proposed that aid in elicitation of a patient's conception of the cause, process, duration and outcome of an illness as well as healing strategies and resources that the patient considers to be appropriate.[4,6] Understanding a patient's conceptualizations and preferences constitutes the first step. Questions such as, What do you feel may be causing your problem? How do you feel the illness is affecting you? and What do you feel might be of benefit? are examples of the shift in focus.

Explain. Explanation or communication of a "Western medicine" model is the next step. This may be a biomedical model but often the provider is making an educated guess, for example, that a patient's diarrhea is indeed due to an intestinal virus as opposed to toxins from contaminated food or psychosocial stress. In the primary care setting, treatment is frequently initiated without a definite diagnosis or biomedical model. However, it is critical to the success of the interaction that the care-giver have a strategy and that the strategy be conveyed to the patient.

Acknowledge. Acknowledgment of a patient's explanatory model occurs next or is integrated into the previous explanatory step. Based on an understanding of the explanatory models of both patient and provider, areas of agreement can be pointed out and potential conceptual conflicts understood and resolved. Resolution may involve bridging the conceptual gap between disparate belief systems. In many instances there is no therapeutic dilemma involved and a patient's own model can be incorporated into the system of care. If the provider feels that a patient's explanatory model and its consequences may have possible deleterious effects, such as a toxic medicinal substance, then an attempt must be made to market a more appropriate model leading to the next step. An example of a counterproductive explanatory model and resultant intervention is the consumption of pickle brine for hypertension—called "high blood" by some southern blacks. "High blood" is characterized by too much blood and treated by avoiding rich foods and consuming pickle brine, an "astringent" substance. The high sodium content of pickle brine would likely be deleterious in the face of blood pressure elevation.[10]

Recommend. Within the constraints imposed by a patient's and provider's explanatory models, a treatment plan can be developed. Patient involvement in the treatment plan is important. This step constitutes an extension of such an effort to include cultural parameters when appropriate culturally relevant approaches can be incorporated into the recommendation to enhance the acceptability of the treatment plan.

Negotiate. Negotiation is perhaps the key concept of the proposed LEARN model. It is necessary to understand a patient's perceptions and to communicate the provider's perspective so that a treatment plan can be developed and negotiated. There may be a variety of options from the biomedical, psychosocial or cultural approaches that could be appropriately applied. The final treatment plan should be an amalgamation resulting from a unique partnership in decision making between provider and patient. A patient can truly be involved in the instrumentation of recovery if the therapeutic process fits within the cultural framework of healing and health.

Application of Guidelines

To illustrate the application of the LEARN model, we have selected examples from the experiences of our staff and students. We have chosen a separate case to exemplify each concept of LEARN. Although all or most steps in the model are involved in every clinical encounter, the cases were chosen to best illustrate each concept specifically.

- *Listen*

A 28-year-old Vietnamese woman, a social work student, was first seen in the Family Practice Center in autumn of 1982 because of weight loss, mood swings, nervousness, sweaty palms and an increased number of bowel movements. She had lived in the United States for five years. Initially she volunteered that she had been extremely depressed ten years earlier and had once attempted suicide. She had an established diagnosis of retinitis pigmentosa and was legally blind. She was living with her mother and two siblings and was entering college to study social work. On initial examination there were findings consistent with retinitis pigmentosa. Lid lag was also noted. Initial laboratory studies elicited values consistent with mild hyperthyroidism and she was started on a regimen of propranolol hydrochloride taken orally.

She was seen regularly and had a constellation of symptoms including abdominal pain, mute attacks during which she could not open her mouth, twitching and palpitations. After taking propranolol she felt very fatigued and weak and had an episode of syncope after which she refused to take further medication. Additional symptoms developed including squeezing substernal chest pain. Repeat thyroid function testing was normal.

There was no apparent physical explanation for the symptoms and it was felt that she was suffering from anxiety and depression related to her disability and life stress. Supportive approaches were instituted with regular counseling visits. Relaxation training and a life journal were begun. The technique used for relaxation included both breathing exercises and visualization.

Shortly after these measures were instituted the patient presented in a very agitated state and said that

the pleasant visual images she attempted to conjure turned "dark and scary." She also related that a childhood diary had been taken from her by one of her sisters and that the contents had been ridiculed. This made it very difficult for her to keep the recommended life journal. At this time, with encouragement, she related some very important events in her childhood. When she was 8 to 10 years of age her affliction was felt by her family to be due to her possession by an evil spirit, and a healer was summoned. The attempt at exorcism failed and this was interpreted as a sign that her illness was a form of punishment for her transgressions in a past life. She was virtually locked away in a back room for several years before the events that led to her immigration.

She stated she no longer held this set of beliefs, but she continued to worry about whether she was a good person. Her physician agreed with her rejection of the ideas held by her family and suggested that her studies in social work and her commitment to help people were indeed evidence of her goodness and worth.

She moved out of her home to campus housing and has improved somewhat. She continues to visit the Family Practice Center for supportive care.

Cultural context. The medicoreligious beliefs of Vietnam derive from such a variety of sources that specification of exact religious context of the healing rituals of this patient's early life is difficult.

There have been historical interchanges of Ayurvedic medicine, with its roots in Galenic humoral pathology, influenced by Hinduism and Buddhism, especially in Southeast Asia.[11-16] Chinese medicine, which is more closely related to Confucian and Taoist religious philosophies, has made an additional contribution. More recent influences come from Catholicism and Western medicine. Local indigenous beliefs and practices also no doubt exert some influence.[17(pp xviii-xxix)]

Attribution of illness to possession by spirits or demons is consistent with all of these religious traditions (including Catholicism, at least historically). Whichever temple and priest or shaman the patient's family applied to for help, her status as a victim of a malevolent source would have been validated by successful exorcism. This would have been confirmed by the return of her eyes to normal appearance. Failure of repeated exorcistic rites to alleviate the symptoms led to the conclusion that her deviant appearance was a mystical mark, a sign of evil committed in a former life. This conclusion transformed her from victim to perpetrator. In a family whose members include all of the living, dead and as yet unborn, the final diagnosis shamed the family in perpetuity. This was the justification for confining the child in the house and restricting her social interactions. The family was, literally, attempting to hide their shame. The psychologic burden that this explanation placed on the patient resulted in somatization of complaints. Mental illness, which bears strong negative sanctions for similar reasons, would have constituted yet another mark against the family.

The patient migrated with her family to the United States when she was an adolescent. The process of acculturation and an alternative biomedical diagnosis provided a context for a change of attitudes and perception of self-worth. Although several people whom the patient had consulted over time (social workers and health care providers) had felt that there was a troubling "cultural component" in her medical history, the patient had never been able to discuss it fully. Careful probing and an open, nonjudgmental attitude on the part of the resident physician allowed the patient to divulge the complete background information and to acknowledge the lingering self-doubt these experiences had produced. She was then able to initiate steps for improvement such as removing herself from the family context, which produced continuing stress and reinforced a negative self-image, and continuing her studies in a helping profession, which confirmed her goodness.

- *Explain*

A 21-month-old Mexican-American male infant with recurrent onset of fever, runny nose and noisy breathing was brought to the clinic by his mother. The mother noted that the child had been sleeping restlessly and making sighing noises while asleep.

On physical examination, he was found to have edematous mucous membranes and mucoid nasal discharge consistent with an upper respiratory tract infection (URI).

The mother stated that she was very concerned because two months earlier the child had had a major motor seizure that she associated with a high fever. She felt that the seizure had precipitated *susto* (fright disease), as evidenced by the sighing and restlessness during sleep, and wanted a regimen to control fever and prevent a worsening of the child's *susto.*

The resident physician discussed upper respiratory tract infections and their effects on breathing. He suggested a decongestant for relief of symptoms. He also confirmed the relationship of fever to seizures and advised continued use of antipyretics. He demonstrated the use of sponge baths to reduce fever and emphasized the importance of fever control in preventing seizures. In addition, he suggested that the mother consult a *curandera* (folk healer) concerning her questions about *susto.* The patient has subsequently been seen for routine visits and has had no further seizures or other significant problems.

Cultural context. Susto is a Latin-American folk illness that is caused by fright.[18-22] The source or cause of fright might be anything from a simple startle response to an encounter with spirits. Children are particularly susceptible to *susto.* Symptoms vary widely, but the sighing and restlessness or poor sleep pattern exhibited by the patient are common manifestations. The mother's explanatory model for this case of *susto* was as follows:

URI→fever→seizures→*susto*→sleep disturbance

The provider was able to give a detailed biomedical explanation of that portion of the patient's explanatory

model to which it was applicable and to recommend consultation with a folk specialist for that portion that lay outside the purview of modern medicine.

- *Acknowledge*

A 25-year-old Vietnamese woman was seen for a routine prenatal examination. As part of her evaluation she had blood drawn for laboratory testing. Within the next few days she returned with a variety of symptoms including weakness, fatigue and coryza. She attributed this to having blood removed, feeling that removal of blood weakens the system and causes illness.

Her provider, a Vietnamese physician, was aware of the belief and acknowledged it, but also explained how much blood volume she actually had and gave the example of persons donating blood, a much larger volume, without symptoms.

She was pleased with the explanation, seemed to feel less fearful and her symptoms abated.

Cultural context. The probable influence of Chinese medicine or Ayurvedic medicine (or both) in Southeast Asia is seen in this patient's response to blood tests. Edwards[23] describes the following physiological process from Chinese medical theory: "The connection between food, [blood], sex and health is found in the transformational formula in which seven units of the precursor yields one unit of the subsequent product:

Food→blood→*jing*→*qi*→*shen*"

Edwards defines the terms as follows: *jing*="sexual fluid," which is a vital substance; *qi*="breath" or "life energy" (also written *chi*); *shen*="ethereal energy." A similar process has been described from Ayurvedic medical theory, which could be outlined as follows:

Food→chyle→blood→flesh→fat
bones→marrow→semen[24]

Because several physiological systems are involved in the production, transportation and storage process —that is, digestive, genitourinary, circulatory and respiratory—symptoms can be diffuse and varied. Since all descriptions indicate a geometric reduction between precursor and product, the consequences of interruption of the cycle would increase geometrically in seriousness at each earlier step in the process.

The patient's and the provider's explanatory models were similar in that they both believed blood loss to constitute a potential threat to health. Their explanations differed in the amount of blood that must be lost to pose a problem. By relating the amount of blood removed to the total blood volume and comparing this with the much larger quantities safely removed from blood donors, the physician was able to reassure the patient and to effect alleviation of symptoms.

- *Recommend*

A 38-year-old Mexican-American man was seen in the Family Practice Center for chronic genitourinary problems. He had experienced hematuria and right flank pain two years before. In addition there had been recurrent episodes over 18 years of right flank pain and dysuria, diagnosed as urinary tract infections. He did not use analgesics. Examination of the external genitalia and prostate was unremarkable. He had no abdominal or flank tenderness. Analysis of urine showed 50 to 100 leukocytes per high dry field. An intravenous pyelogram showed a localized hydronephrotic area in the upper pole of the right kidney.

He was seen by a urologist who carried out retrograde pyelograms. These showed a large calyceal diverticulum connected with the right collecting system, with hydronephrosis of the upper pole of the kidney.

Surgical treatment was recommended. The patient expressed considerable reluctance to have an operation. When questioned by his family physician he expressed concern that his "blood was low" and that he would have trouble going through an operation under the circumstances. His physician discussed the amount of blood that could be expected to be lost with a partial nephrectomy and also the total available blood supply in the body. He suggested that a surgical procedure be delayed for a period to allow the patient to "build up his blood" with appropriate medication. This was quite acceptable to the patient and the consultant urologist.

He subsequently underwent uneventful partial right nephrectomy.

Cultural context. Blood is "hot" according to the hot-cold system of humoral pathology as practiced in Latin America. Blood is also associated with strength, both in the health and the sexual sense. Having a large supply of blood makes one strong and healthy, but is also associated with virility and hence with machismo. Menstrual blood, semen and sexual activity are very hot.[25] Men's blood is hotter than women's blood.

The patient felt a need to build up his blood supply in order to have reserve strength for an operation because he expected a significant amount of blood to be lost during it. He was willing to accept the recommendation that he take iron to help build blood. However, an equally acceptable way to build blood would have been to eat blood products such as fried blood or blood sausage. Organ meats are good for building up strength and blood supply. In the Mexican-American folk system, an abundant and varied diet builds physical reserves, including a healthy supply of blood.

By describing the surgical procedure, including control of bleeding, the resident physician was able to alleviate some of the patient's concerns about blood loss. The provider was then able to recommend a treatment plan acceptable to the patient by prescribing "blood building" medicines and by scheduling the operation following a delay of fixed duration that the patient concurred would be adequate to prepare himself.

- *Negotiate*

A 48-year-old black man was seen because of severe hypertension and congestive heart failure associated

with far-advanced renal insufficiency. Initially he was managed conservatively. It became obvious, however, that he had reached a stage at which renal dialysis was his only hope for survival.

When he was approached about the possibility of hemodialysis he declined, stating that he was a devout Christian and felt that the will of God was of prime importance and that he would wait for God's intervention rather than accept dialysis.

His physician acknowledged the importance of God's influence, but suggested that the opportunity for dialysis as a means to control his condition might be the way God had intended for him to survive. Indeed, there was nothing in the Bible that prohibited dialysis and God helps those who help themselves.

The following day the patient consented to hemodialysis and now has a functioning bovine shunt and is doing well.

Cultural context. The socioreligious context of this patient's explanatory model was fundamentalist Protestantism. The direct intervention and control of health by God is supported in the Old Testament (Exodus 4:11): ". . . who maketh the dumb or deaf, or the seeing or the blind? Have not I the Lord?" The New Testament contains dozens of examples of the healing powers of Christ.[26] While one common alternative to treatment is faith healing,[27] this patient seemed to be relying on the Old Testament with healing based on direct intervention by God. He suggested that he felt that God did not intend him to die yet and would intervene on his behalf. The provider was able to call on other aspects of Christian beliefs such as "the Lord helps those who help themselves" and that God sometimes works through human agents: "For to one is given by the Spirit the word of wisdom; . . . to another the gift of healing by the same Spirit" (I Corinthians 12:8-9).

The implication was drawn that the physicians and dialysis might be the instruments through which God intended to intervene. Medical intervention was thus translated into a construct that did not violate the tenets of the patient's faith. By using beliefs from the patient's own religious background, the provider was able to negotiate acceptance of recommended biomedical treatment.

Summary and Conclusions

Given current demographic trends it is probably unrealistic to assume that health care providers can gain in-depth knowledge about the health-affecting beliefs and practices of every ethnic or cultural group they are likely to encounter in practice. The processes of acculturation, interethnic variation and social change also serve as confounding agents in predicting knowledge, behavior and attitudes. Social class differences, too, provide striking variability. We have, therefore, chosen a process-oriented model by which the cultural, social and personal information relevant to a given illness episode can be elicited, discussed and negotiated or incorporated.

However, it is common in our experience for patients of different beliefs to be reluctant to discuss this problem for fear of criticism or ridicule. It is certainly of value for providers who deal with culturally diverse patients to have some understanding of common basic conceptions of health, illness and anatomy held by these persons. Much work needs to be done in codifying these conceptions and making them available to professionals in medicine.

The foregoing examples serve to illustrate some of the means the members of a family practice residency program have used for enhancing communication and promoting the integration of patients' and providers' perceptions of needs and solutions into the therapeutic process.

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